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DISSOCIATIVE IDENTITY DISORDER:
INTEGRATION VERSUS NON-INTEGRATION

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Kris Jane Strande

June 2000

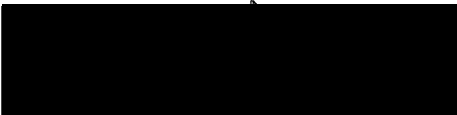
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Approved by:


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6/13/00
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ABSTRACT

For the mental health professional, the client with Dissociative Identity Disorder (DID) can be exciting, exhausting and frustrating. Formal education offers little help in treatment and diagnosis of this disorder. This paper will explore the most utilized treatment goals available to the professional and the client. Although most "experts" in the field of Dissociative Disorders subscribe to the treatment goal of integration, this study challenges that idea. As the results of the study indicate, integration was not the most utilized goal of treatment among the participants of this study.

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I would also like to thank all those individuals with DID, large and small, who imparted their knowledge of their "gift" of survival to me: All of Us, Angelica, Anthony, Arlys, Aryn, Baby, Candace, Coach, David, Gary, Isaiah, Michael, Michelle, Nobody, Rachel, Rick, Ricky, Robert, Roger, Sandy, Steven, Susan, Thomas, Tim; et al.; JJ; Me too; Vince & Friends.

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CHAPTER ONE

INTRODUCTION

...gods, strange gods, come forth from the forest
into the clearing of my known self, and then go back.
D.H. Lawrence, Studies in Classic American Literature

Problem Statement:

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), is one of the most misunderstood and understudied psychological disorders today. The above quote, by D.H. Lawrence, illustrates the mysterious phenomenon of DID. This disorder has not only intrigued a great many individuals, but it has also been a great source of pain for those whose lives have been affected by the disorder.

The official definition of Dissociative Identity Disorder as put forth by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV,) is as follows: "...characterized as the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by

the inability to recall important information that is too extensive to be explained by ordinary forgetfulness" (DSM IV, 1994, p.477).

The large number of misdiagnosis and underdiagnosis of DID has become a public health problem (Kluft, 1985). The lag in proper diagnosis and treatment of DID presents a financial and emotional burden on the client, as well as on society as a whole. Until more legitimate research has been undertaken, the plight of the Dissociative Identity Disorder client remains grim.

Formal training in diagnosis and treatment of this disorder is virtually non-existent. What little is taught to future mental health professionals focuses on diagnosis, with a paucity of information on effective treatment. Along with this lack of preparation often comes skepticism and disbelief that still surrounds the disorder. Mental health professionals are told that this disorder is extremely rare and that they are likely to never see it in their practice. Consequently, when faced with the signs and symptoms of DID, the mental health professional looks

to more commonly accepted diagnoses for explanation (Fuller, 1999).

According to a study by Kluft (1985), the DID client is given an incorrect diagnosis, on average, three times, and is not correctly diagnosed for approximately 6.8 years. In spite of the fact that Dissociative Identity Disorder is not a modern day phenomenon, problems surrounding diagnosis and treatment still persist today.

Ross (1989) has stated that DID/MPD can be traced back to the ancient history of Egypt, with the myth of Osiris. Simply put, Osiris is the story of fragmentation of the self, thus similar in nature to DID. Prior to modern world thinking of the nineteenth century, the evolution of our understanding of DID can be traced through a period in which suffering individuals were thought to be demon possessed and exorcisms were routinely performed. The post-demon era can be marked with the beginnings of psychotherapy. Generally speaking, psychotherapy was not tied to any religious beliefs, making the theories somewhat agnostic or atheistic. This accounted for the change from

demon possession to a more scientific theory regarding DID among many professionals (Ross, 1989).

Problem Focus:

The issues to be addressed in this study pertain to the goal of treatment for the DID client. According to a follow-up study by Ross in 1997, clients who underwent integration as a goal of treatment showed more improvement than those clients who did not integrate. However, Ross himself admits that the field of dissociative disorders is lacking in systematic empirical studies. Yet, in the absence of empirical substantiation, most books on the subject of treatment of the DID still profess that integration is the goal of choice.

For the purpose of this paper, integration is defined as the continual process of undoing all dissociative separateness (Braun, 1986). The use of the word *integration* is problematic in itself, as there is no standard definition of the word within the field. Although used extensively in almost every book and article written

on the subject, *integration* is often used synonymously with *fusion*.

For the mental health professional that suddenly finds him/herself in the company of a client exhibiting symptoms of Dissociative Identity Disorder, finding help in making a proper diagnosis and in treatment planning is difficult. Lacking training regarding DID, the mental health professional has no recourse but to consult a colleague, most likely equally unprepared, or begin scrambling through books for answers or refer the client to someone else. In the limited available literature, the names of four mental health professionals can be found over and over regarding the subject at hand: Bennett Braun, Richard Kluft, Frank Putnam, and Colin Ross.

Unquestionably these four men, who have spent the last several decades studying the phenomena of DID, are experts. Although on the surface there appears to be a clear consensus as to the most appropriate goal of treatment for individuals with this disorder, there is found, upon further study, a decided lack of agreement.

Although integration is the treatment goal of choice to which most "experts" subscribe, the question remains: whose choice is this? Is *integration* a clinically sound goal of therapy, necessary for emotional and mental health of the client? Or is it a goal born of ignorance and fear of the unknown? Braun (1986) identified 6 categories of problems that contribute to relapse post-integration.

These categories, which often overlap, are:

- ❑ Alters emerge later that had either pretended to have already integrated or had yet to emerge, fearing difficult memory work.
- ❑ Alters that had secretly existed, pretending to be another alter, with the intent to take over the body once therapy ceased.
- ❑ Alters emerged who felt that they needed to stay-behind in order to keep the body safe from further possible abuse.
- ❑ Adequate working-through of memories was not completed for some alters.

- The client integrates too quickly, without proper preparation, in order to please the therapist.
- Alters perceived integration as a threat to their existence.

Braun believes that these six categories can be controlled for, and that integration is possible. In order to control for these six categories, however, the client must be reassessed to assure that the integration is still intact. However, according to Braun's six categories, integration appears to have never taken place. If relapse is possible, is integration the best goal of treatment?

According to Kluft (1983), there are four main approaches to treating DID that are currently being used by mental health professionals:

- Integrationalism: the stated goal is integration, encouraging alters to cede their separateness and eventually join together as one.
- Personality-focused: the stated goal is focusing on inner diplomacy, encouraging collaboration of alters, leading to a harmonious living without loss of separateness.

- ❑ Adaptationalism: the stated goal is working on the here-and-now problems and increasing functionality of the individual.
- ❑ Minimalism: the stated goal is discouragement of work with individual alters, thus ignoring the DID diagnosis.

The goal of treatment for any client, regardless of their diagnosis, depends on the presenting problem(s). Most DID clients who find themselves in therapy do not present for their primary diagnosis of DID. In fact, most (but not always) clients are unaware of the alternate identities co-existing in their psyche. Instead, they may present for dysfunctional behaviors that are related to Major Depressive Disorder, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, Borderline Personality Disorder, Antisocial Personality Disorder or numerous other disorders. Suicidal ideation, depression, unexplained compulsions, self-mutilation, and/or criminal involvement are often the presenting symptoms of a DID client (Fuller, 1999). They are typically in need of stabilization to help them return to their pre-crisis level of functioning or

above. Consistent with the philosophy of social work, this would be approached from a strengths perspective. The universally accepted cornerstone of social work is to view the client from the strengths perspective, not the disease perspective of the medical model.

This study will dispute integration as the best goal of choice for the DID client. Alderman and Marshall (1998) argue that although integration is often the ultimate goal with the DID client, it should be approached with caution and is the choice of the client and not that of the therapist. To the DID client, integration of alters often feels as if they are losing or killing off part of themselves. Alternate personalities often function as an inside family, guiding and supporting one another.

The research methodology for this study was based on the use of self-report questionnaires, which were mailed to mental health professional, who treat DID clients. The following questions will be addressed in this study:

- Do mental health professionals utilize any of the four treatment goals outlined in this paper?

- Which of the four goals is most often used?

CHAPTER TWO

LITERATURE REVIEW

History:

During the early part of the nineteenth century, interest in DID began to grow among several famous theoreticians, notably Freud, Jung, Janet, Charcot, Liebauult, Prince, Bernheim and James. The misunderstood phenomenon was studied in France and in the United States. However, by 1910 the interest in DID had all but vanished. Freud's seduction theory, discounting incest between fathers and daughters, and interest in Schizophrenia were partially to blame for the loss of interest in DID. Individuals with dissociative symptoms were either labeled schizophrenic or thought to be suffering from incestuous fantasies (Ross, 1989).

Between the years 1910 and 1980, DID was no longer considered for serious scientific study. The reemergence of interest in DID as a serious and valid mental disorder came from three occurrences. The first was an interest in hypnosis following World War II. The second was related to

the trauma experienced by Vietnam veterans. And the third occurrence was the Women's Movement, which pushed to expose incest. In 1980, MPD/DID was added to the Diagnostic and Statistical Manual of Mental Disorders, Third Edition. From this point on, the mental health field began to turn what was once considered *demon possession* into a legitimate disorder with a scientific body of knowledge (Ross, 1983).

Theoretical Perspective:

Past research on DID have been guided from the psychodynamic perspective. Supportive-expressive in stance, and in conjunction with hypnosis when necessary, this approach has been utilized in the majority of reported successful cases (Spiegel, 1993). By bringing into conscious awareness the unconscious etiology of behavior and motivation, the mental health professional attempts to help the client understand why they are the way they are. The psychodynamic approach lays the foundation for treatment for DID clients as utilized through specific approaches, such as Virginia Satir's Family Systems approach and Play Therapy, which is often utilized when

working with young child alters. Fritz Perls' phenomenological approach of Gestalt, and the disease theory/medical model are two other approaches to the treatment of the DID client (Bryant. Kessler. Shirar. 1992).

Bryant, Kessler and Shirar (1992) give a brief look at the first three theories; family systems, Gestalt therapy, and play therapy.

Applying Satir's Family Systems Theory, alters (alternate personalities/identities) are viewed as living within a system in much the same way individuals live within a family. All members/alters contribute to the energy that keeps the system functioning.

The basic philosophies of Perls' Gestalt therapy can also be applied. In Gestalt therapy the individual is encouraged to discover wholeness and/or integration in how they think, feel and behave (Corey, 1996). In working in the here-and-now of Gestalt, alters bring forth past traumatic experiences through abreaction, helping to release them from the experience of the trauma.

The theory behind play therapy is that children respond best to therapy if allowed to express their feelings and tell their story through a "medium" in which they understand, that of play. Through the use of play therapy techniques, child alters are allowed to express their pain.

The disease theory, also known as the medical model, can be found in numerous books that subscribe to the belief that DID is something to be cured. The Diagnostic and Statistical Manual of Mental Disorders itself is based on the medical model/disease model which espouses pathology. According to Webster's Encyclopedic Unabridged Dictionary, the word pathology means "...the conditions and processes of a disease...any deviation from a healthy, normal, or efficient condition."

Ross states, "The goal of treatment of MPD is not palliation. It is cure. Lesser outcomes may be all that is possible in certain cases, but they are not cure" (Ross, 1989, p.204). It is clear that Ross, a known expert in the

field of Dissociative Disorders, is speaking from the disease theory perspective.

Viewing DID from the Native American perspective, Summer Rain states that alternate personalities are merely misdirected spirits, not a "split" in personality (Summer Rain, 1991). This appears to contradict the disease theory or the need for integration of personalities.

Vastly deviating from the previous mentioned theoretical perspectives of DID, the guiding theory of this study is that of the strengths perspective. The focus of this theory is on the strengths and abilities of people, not on the pathology. Pathology serves only to give emphasis to problems, defects, and lack of abilities, thus ignoring the positive qualities in people (Zastrow, 1997). In a social work textbook written more than 25 years ago, the role of the Social Worker was described as an individual who helps others to achieve a more satisfactory level of social functioning (Fink, 1974). This author seems to capture the essence of the helping profession, whereas Ross appears to be caught in the disease model.

However, Ross eventually contradicts himself when he states that if the individual does not improve, interventions are worth nothing (Ross, 1989).

Treatment:

In a study completed by Ross and Ellason (1997), clients who underwent integration as a goal of treatment improved more than those clients who did not. However, Ross himself admits that there is an absence of empirical evidence to support this belief. Although interesting, this article did not empirically demonstrate that integration is the best goal of treatment for the client.

Putnam (1989) is the first to address the fact that integration may not be the best approach to treatment. He states that it may appear that there is a general consensus among mental health professionals regarding integration as the best goal of treatment with DID clients however, this approach may be unrealistic with many patients. Putnam speaks of Richard Kluft who also questions the legitimacy of integration. Kluft, citing Psychiatrist David Caul, speaks of the desire to have "...a functioning unit, be it a

corporation, a partnership, or a one-owner business"

(Putnam, 1989, p.301).

However, the guidelines set forth by the International Society for the Study of Dissociation, state that integration is the overall treatment goal with the DID client. In their comprehensive guidelines for treatment, the goals are stabilization of dysfunctional behavior and symptoms, restore functioning, and improve relationships. These goals must lead to integration of mental functioning. Sadly, the theoretical underpinnings of this organization appear to be disease oriented. Mental functioning from the strength perspective would not necessarily be all inclusive of integration.

Braun (1986) cites six categories of relapse. Relapse is defined by Braun as the detection of a new or undiscovered personality or the return of separate identities that were thought to have integrated (Braun, 1986). Braun believes that these six categories can be controlled for, and that integration is possible. In order to control for these six categories, however, the client

must be reassessed to assure that the integration is still intact. If a relapse has occurred, the client is then re-integrated. Is this not a contradiction in itself? If a client must be continually re-integrated, then how can true, stable integration be possible?

Kluft (1993) cites that there are four main approaches to treating DID that are currently being used by mental health professionals: integrationalism, personality-focused, adaptationalism, and minimalism. Kluft states that experts in the field of DID differ in their opinion regarding the use of integration. He points out that most experienced mental health professionals value integration as a goal of treatment, however he believes that these clients remain vulnerable due to their history of dissociation which weakens the ego. Kluft goes on to state that in a study of client's who elected not to integrate, most of them relapsed or naturally moved toward unification. It is supposed that Kluft is using the word *unification* in the same manner as *integration*.

An article written by Turkus (1992), is an example of the misguided information that exists in the field regarding treatment of DID. This author explains that midpoint in the therapeutic process with the DID client, integration of alternate personalities takes place. Turkus offers no alternative to treatment other than integration of personalities. This is an example of the type of article that an inexperienced mental health professional is apt to read. This leaves the professional to believe that integration is the only choice of treatment.

Multiple Personality Disorder from the Inside Out by Cohen, Giller and Lynn W. (1991) is an excellent resource for the mental health professional and for the layperson that desires to learn more about DID. This book is a compilation of personal accounts from actual DID clients. Although this book appears to support integration, it also makes a point of stating that being (mentally) healthy does not require integration of alters.

Alderman and Marshall (1998) state that integration is often the long-term treatment goal for many professionals,

however, they believe that the decision should be that of the client and not the therapist. The clients' opinion should be taken into consideration. These authors point out that the client may be functioning very well as a non-integrated system.

Although many experts espouse that integration is the best goal of treatment for the DID client, they are lacking in empirical substantiation. This methodological limitation presents a gap in literature and in scientific research.

The purpose of this study is to help close the gap by exploring current treatment goals currently in use with DID clients. Without this information, integration may be nothing more than a treatment goal born out of naiveté. In reality, there is no way of knowing if an alternate personality is still hiding in the forest known as the psyche.

CHAPTER THREE

METHODS

Sample:

Study participants were recruited by using a non-probability convenience sampling. Ninety mental health professionals who are members of the professional organization known as the International Society for the Study of Dissociation (ISSD) in the year 2000 were chosen to participate.

Procedure:

Members of this organization were chosen because of ISSD's reputation for working with DID clients. Survey questionnaires were mailed only to mental health professionals with a California address. The participants were chosen by picking the name of the first person in every city in California that was listed on the ISSD 2000 membership list. Student members and Affiliate members were skipped, and the second name on the list was chosen. The purpose of skipping these members was to assure that

the participant was currently working with DID clients. Additionally five mental health professionals known to the researcher for their work with DID clients also received questionnaires. The total number of questionnaires mailed to participants was 95 with a return rate of 33 questionnaires. Of the 33 returned, five declined to participate for various reasons and one was returned stamped "forwarding order expired." The various reasons for not participating were comprised of: no time to do this; no longer working with DID clients; I see no patients; retired; returned, not filled out.

Instrument and Data Collection:

The researcher designed the instrument used for the data collection. No previously tested instrument was available to the researcher.

The data collected consisted of background information related to characteristics of the mental health professional and the varying treatment approaches they employed. The independent variables are the background information: discipline, number of years in practice,

gender, education and educational institution. The dependent variables are the different types of treatment: integrationalism, personality-focused, adaptationalism, and minimalism. The level of measurement was nominal, as this study was exploratory in nature.

The validity and reliability of the instrument was constrained by the lack of clarity regarding the subject of integration, within the field of Dissociative Disorders.

CHAPTER FOUR

RESULTS

The sample studied was composed of six males (21%) and 22 females (79%). The different disciplines were as follows: 11 Psychologists (39%), 12 Marriage and Family therapists (MFT)(43%), two Licensed Clinical Social Workers (LCSW) (6%), one Master of Social Work (MSW) (4%), one Medical Doctor (MD) (4%), one declined to state (4%). The educational backgrounds of the participants were as follows: 11 Ph.D's (39%), 15 Masters (55%), one Medical Doctor (3%), one other (3%). All of the participants were geographically located throughout California.

Table 1: Gender

Gender	Number	Percentage
Male	6	21%
Female	22	79%
Total	28	

Table 2: Discipline

Discipline	Number	Percentage
Psychologist	11	39%
MFT	12	43%
LCSW	2	6%
MSW	1	4%
Psychiatrist	1	4%
Declined to State	1	4%
Total	28	

Table 3: Education

Education	Number	Percentage
Ph.D.	11	39%
Masters	15	54%
Medical Doctor	1	4%
Other	1	4%
Total	28	

Five hundred thirty-five DID clients were stated to have been treated by the 28 respondents in their years in practice. Eighty-five DID clients were stated to currently be in treatment with the sample population. The range of clients treated by an individual mental health professional ranged from two clients to 75 clients. The mean number of years in practice amongst the sample population was 26 1/2. Ranging from nine years to 44 years.

Psychologists treated 226 DID clients (42%), Marriage, Family therapists (MFT) 174 (33%), Licensed Clinical Social Workers (LCSW) 54 (10%), Master of Social Work (MSW) 25 (5%), Psychiatrists 50 (9%), and "declined to state" six (1%).

Table 4: Discipline to Number of Clients

Discipline	Number of Clients	Percentage
Psychologist	226	42%
MFT	174	33%
LCSW	54	10%
MSW	25	5%
Psychiatrist	50	9%
Declined to State	6	1%
Total	535	

Table 5: Treatment Effectiveness

Treatment Effectiveness	Not Effective	Seldom Effective	Often Effective	Highly Effective
Minimalism	9	4	1	1
Personality-focused	1	0	15	10
Adaptationalism	0	1	14	11
Integrationalism	1	3	11	6

Adaptationalism was the most utilized treatment with 370 clients treated to this level. Personality-focused was the second most utilized treatment with 349 clients treated to this level. Integrationalism was the third most

utilized treatment with 122 clients treated to this level. Minimalism was the least utilized treatment with eight clients treated to this level.

Table 6: Treatment Utilized

Treatment Utilized	Number of Clients	Percentage
Minimalism	8	1%
Personality-focused	349	41%
Adaptationalism	370	44%
Integrationalism	122	14%
Total	849	

Psychologists utilized Adaptationalism most often (150), Personality-focused second (139), Integrationalism third (74), and Minimalism the least (5). Marriage, Family therapists (MFT) utilized Adaptationalism most often (165), Personality-focused second (156), Integrationalism third (19), and Minimalism the least (2). Licensed Clinical Social Workers (LCSW) utilized Adaptationalism (54), Personality-focused (54), Integrationalism (29), and Minimalism not at all (0). Master of Social Work (MSW) and Psychiatrists did not utilize any of the four treatment types studied. One participant who declined to state his/her discipline utilized Adaptationalism (1),

Personality-focused (0), Integrationalism (0), and Minimalism (1).

Table 7: Discipline to Treatment Utilized

Discipline	Minimalism	Personality-focused	Adaptationalism	Integrationalism
Psychologist	5	139	150	74
MFT	2	156	165	19
LCSW	0	54	54	29
MSW	0	0	0	0
Psychiatrist	0	0	0	0
Declined to State	1	0	1	0
Total	8	349	370	122

Adaptationalism effectiveness rating resulted in, one seldom effective; 14 often effective; 11 highly effective.

Personality-focused effectiveness rating resulted in, one not effective; 15 often effective; ten highly effective.

Integrationalism effectiveness rating resulted in, one not effective; three seldom effective; 11 often effective; six highly effective.

CHAPTER FIVE

DISCUSSION

This study hypothesized that the treatment goal of integration may not be the best goal of choice for the DID client. Through the use of exploratory questions, the most utilized treatment goals with this population were uncovered. Mental health professionals from different disciplines throughout California were asked which of the four goals, outlined in the questionnaire, they utilized most often. These same practitioners were asked which of these goals they viewed as most effective when working with this population.

As stated in the review of available literature, integration is often viewed as the best goal of treatment. However, the results of this study revealed that integration is not the most utilized goal of treatment overall, nor does the sample population view it as the most effective goal of treatment. Instead, the treatment goals of Adaptationalism and Personality-focused were shown to be

the most utilized and effective when working with the DID client.

These treatment goals are consistent with the strengths perspective, which is the cornerstone of the profession of Social Work. Dissociative Identity Disorder clients are not viewed as something to be cured as in the medical model, but rather each individual is helped to better cope with the situation at hand.

Psychologists and Marriage, Family therapists were shown to treat this client population more frequently than Licensed Clinical Social Workers (LCSW) and Masters in Social Work (MSW). These findings are not surprising, given the wide range of non-clinical jobs that LCSW's and MSW's are often employed.

The largest limitation of this study can be found in the questionnaire itself. As with any self-made questionnaire, problems of validity and reliability arise. This was evident by the numerous comments handwritten on the questionnaire. Some of the opinions of the mental health professionals consistently stated that all of the

goals (Integrationalism, Personality-focused, Adaptationalism, and Minimalism) are stages and not goals within themselves. Keeping this in mind, there is no way of knowing how the participant answered the questionnaire. For example, if Integrationalism was the end result of treatment, did the participant also count the client into the other stated goals? This discrepancy can not be accounted for.

This study was also limited by its' small sample size. The primary utilization of ISSD members as participants may also compromise the findings based on ISSD's stated belief regarding the goal of integration. Because of these two factors, the generalizability of the findings should be cautioned.

The word *integration* presents another limitation to this study. Although the word integration is defined within the survey, the word is often used synonymously with fusion, and may have caused confusion for some participants.

The treatment setting of the professional is another variable that can not be accounted for in this study. A hospital setting versus an agency setting may effect the treatment options available to the mental health professional.

Motivation and the ability of the client may have also acted as a limiting factor to this study. These two traits may have affected which treatment goal the mental health professional chose to utilize.

Implications from the results of this study can be far reaching, in that they indicate that integration was not the most utilized treatment goal or considered to be the most effective by the participants. These results contradict the literature available to most mental health practitioners. Implications indicate that much more research is needed in order to determine what is actually being done in the field versus what is discussed in the literature.

Thus, the implication is as the hypothesis implies: is integration the best goal of treatment, or a goal born out of naiveté?

APPENDIX A

Questionnaire

Practitioner Characteristics

Discipline:

- ☐ Psychologist
- ☐ Psychologist Intern
- ☐ MFT
- ☐ MFT Intern
- ☐ LCSW
- ☐ ACSW
- ☐ ASW
- ☐ MSW
- ☐ Psychiatrist
- ☐ Other _____

Gender:

- ☐ Male
- ☐ Female

Number of years in practice: _____

Education:

- ☐ Ph.D. _____
- ☐ Masters _____
- ☐ M.D. _____
- ☐ Other _____

Institution Name:

Treatment Issues

- ◆ How many adult DID clients have you treated in your practice? _____
- ◆ How many adult DID clients are you currently seeing in your practice? _____
- ◆ Which (if any) of the following do you utilize in treatment with the adult DID client? (adapted from Kluff, 1983)

Minimalism: the stated goal is discouragement of work with individual alters. How many clients? _____

APPENDIX A (continued)

Personality-focused: the stated goal is focusing on inner diplomacy, encouraging collaboration of alters, leading to a harmonious living without loss of separateness. How many clients? _____

Adaptationalism: the stated goal is working on the here-and-now problems and increasing functionality of the individual. How many clients? _____

Integrationalism: the stated goal is integration, encouraging alters to cede their separateness and eventually join together as one. How many clients? _____

Other: Please explain. _____

- ◆ Please rate the following treatment types that you have utilized, for their effectiveness, when working with the adult DID client.

Treatment Plan	No Opinion	Not Effective	Seldom Effective	Often Effective	Highly Effective
Personality-focused					
Minimalism					
Adaptationalism					
Integrationalism					
Other (must correspond with above)					

APPENDIX B

PARTICIPANT RECRUITMENT

Participants will be chosen through a non-random convenience sample. Agencies and/or mental health professionals that are known to specialize in the treatment of adult Dissociative Identity Disorder (DID) clients will be selected. Only mental health professionals that treat adult DID clients will be asked to participate in the study. Survey questionnaires will be mailed to pre-designated agencies as determined by the researcher. Participants will be mental health professionals from different disciplines.

PROJECT DESCRIPTION

Survey questionnaires will be mailed to mental health professionals who are known to treat adult DID clients. The purpose of this study is to answer the proposed research questions:

- Do mental health professionals utilize any of the four treatment categories outlined in this study?

APPENDIX B (continued)

- Which of the four treatment categories, outlined in the study, are most used?

The survey questionnaires will be given with a pre-stamped and pre-addressed return envelope to facilitate data collection. Participants will be asked to return questionnaires by a pre-determined date.

CONFIDENTIALITY OF DATA

Confidentiality of participants will be maintained by the purposeful deletion of identifying information (i.e.- name) on the questionnaire.

RISKS AND BENEFITS

In answering the survey questionnaire, the participant may find it necessary to refer to case records. This, in turn, may cause the participant to spend more than the approximated 20 minutes to complete the questionnaire. The benefit of participating in the study is the furthering of research in an area that has long been neglected.

Serendipitously benefiting both the client and the mental

APPENDIX B (continued)

health practitioner in regards to treatment goals and outcome.

APPENDIX C

CONSENT TO PARTICIPATE

Treatment of the Adult Dissociative Identity Disorder Client

You are asked to participate in a research study conducted by Kris Strande, BS, graduate student from the Department of Social Work at California State University, San Bernardino. The results of the study will contribute to her research project. You were selected as a possible participant in this study because of your work with adult Dissociative Identity Disorder (DID) clients. Your participation in this study is voluntary, as you are free to withdraw or to omit answering any questions.

PURPOSE OF THE STUDY

This study is designed to assess whether mental health professionals utilize any of four specific treatment categories when working with the adult DID client. It will also assess which of the four treatment categories is most often used.

APPENDIX C (continued)

PROCEDURES

If you volunteer to participate in this study, you will be asked to complete a survey questionnaire. The questionnaire will take approximately 20 minutes to complete. The questions that you will be asked to answer pertain to your discipline, type of treatment outcomes achieved with the adult DID client, how many adult DID clients you have treated in your practice.

POTENTIAL RISKS AND BENEFITS

In order to answer the survey questions you may find it necessary to refer to case records, in turn causing you to spend more than the approximated 20 minutes. The benefit of participating in this study is the furthering of research in an area that has been long neglected. This, in turn, will benefit both the client and the mental health professional regarding treatment goals and outcome.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain

APPENDIX C (continued)

confidential and be disclosed only with your permission or as required by law. Confidentiality will be maintained by the purposeful deletion of any identifying information related to the mental health professional and the client (i.e.- name, region).

PARTICIPATION AND WITHDRAWAL

Your participation is VOLUNTARY. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without penalty. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Dr. Rosemary McCaslin at (909) 880-5507

APPENDIX D

DEBRIEFING STATEMENT

This research has been conducted by Kris Strande, BS, graduate student in the Department of Social Work, under the advisement of Jette Warka and Dr. Rosemary McCaslin of California State University, San Bernardino. The purpose of this study is to assess if mental health professionals utilize any of four specific treatment categories when working with adult Dissociative Identity Disorder clients. It will also assess which of four specific categories is most often used. This study has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board at California State University, San Bernardino.

Upon completion of this study, all survey questionnaires will be disposed of in a manner that is accepted for confidential documents. The questionnaires will be shredded by a paper shredder and then disposed of.

As a participant in this research project, you are entitled to a copy of the results. If you are interested

APPENDIX D (continued)

in obtaining the results of this study, you may contact the student at (714)216-7087. Please contact Dr. Rosemary McCaslin at (909)880-5507 if you have any questions about the study.

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